



DEPARTMENT OF
INTELLECTUAL AND
DEVELOPMENTAL DISABILITIES

LONG TERM SUPPORTS EXPANSION REQUEST

General Instructions

Email the completed application to: DIDDProvider.Application@tn.gov

All questions and correspondence regarding the expansion request should be directed to:

Email: DIDDProvider.Application@tn.gov or **Phone:** (615) 532-6530

Date Expansion Request Submitted: _____

Name of Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email: _____

1. Check the service(s) being requested and identify the region(s) the organization proposes to expand service(s):

WAIVER SERVICES	REQUESTED REGIONS		
	WEST	MIDDLE	EAST
DAY SERVICES			
Community Participation Supports			
Intermittent Employment & Community Integration Wrap-Around Supports			
Non-Residential Homebound Support Services			
Supported Employment			
RESIDENTIAL SERVICES			
Family Model Residential Support			
Medical Residential <i>For the Medical Residential service, the Nursing service also has to be approved. Please submit the Provider Application for Clinical and Ancillary Services.</i>			
Residential Habilitation			
Semi-Independent Living			
Supported Living			
RESPIRE SERVICES			
Behavioral Respite			
Respite			
OTHER SERVICES			
Individual Transportation <i>Individual Transportation is only applicable to Respite and Personal Assistance services</i>			
Personal Assistance			
Support Coordination <i>Support Coordination service providers may expand to other regions, but are prohibited from providing other waiver services.</i>			



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2. Give the reason(s) for requesting to add the services(s) marked in section 1
3. Revised agency supervision plan.
4. Revised organizational chart.
5. Job descriptions for new service(s).
6. Definition for new service(s).
7. Home and Community-Based Services (HCBS) Settings Rule:

Date Provider last completed the TN Residential Provider Self-Assessment: _____

Date Provider last completed the Non-Residential Provider Self-Assessment:
if applicable _____

8. If your agency has not submitted an assessment(s), please complete the appropriate assessment(s) and submit with this application.

Printed Name
of Authorized Representative: _____ Signature: _____

Title: _____ Date: _____